CCS Medical Authorization-H.I.P.A.A. Waiver

CCS does not carry medical insurance coverage for students (see Parent-Student Handbook page 5). The federal Health Insurance Portability Accountability Act (H.I.P.A.A.) prevents any medical provider from revealing patient information to a third party without written permission from the parent of a minor. If the student will be 18-years-old at the time of the trip, H.I.P.A.A. requires their signature on such a release form. CCS policy is to obtain both parent and 18-year-old signatures in such cases.

Please note that any charges incurred will be the responsibility of the student's family and their insurance provider. Many policies have different benefits when used out of network and you will need to contact your provider to determine what your coverage will be.

Please complete the Parent/Guardian portion below. Complete the Student portion if the student will be 18 years old during any portion of the year.

Parent/Guardian:

I give my permission for CCS representatives to obtain needed medical care for my

child, _____, during the 2026-2027 school year.
Child's name

Additionally, I give permission for medical providers to discuss medical or billing

information regarding my child with CCS Representatives.

_____ Today's Date_____
Parent/Guardian signature

Student signature: (The section below must also be completed if the student will be 18 or older at time of trip.)
As a legal adult, I give permission for medical providers to discuss medical or billing information regarding my case with my parents:

_____ and CCS Representatives.
Parent/Guardian name

Signed: _____ Today's Date_____
Student signature

Medication Authorization

If my child complains of minor headache or other discomfort, you have my permission to give him/her:

	(Circle One)	How Many?
Ibuprofen (Advil)	**YES NO**	_____
EXTRA-Strength non-aspirin pain reliever (Tylenol)	**YES NO**	_____
Children's Chewable Ibuprofen (Advil)	**YES NO**	_____
Children's Chewable non-aspirin pain reliever (Tylenol)	**YES NO**	_____
Chewable antacid (Tums, Pepto-Bismol, etc.)	**YES NO**	_____

E-Mail Information

Father's (or Legal Guardian's) E-Mail Address _____

Mother's (or Legal Guardian's) E-Mail Address _____

Please include my e-mail address in the school directory. YES NO

Also complete reverse side of this form. Thank you.

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2026-2027 Medical Release and HIPAA Waiver Form

This form is applicable to all official school functions expected of students in a given school year (e.g. retreats, community service projects, field trips, career/college fairs, extra-curricular events, etc.).

I hereby give consent for my son/daughter, _____
to participate in all CCS official school functions. First Middle Last

_____ _____ _____
Signature of Parent or Guardian Date Student's Date of Birth

PARENTAL MEDICAL TREATMENT CONSENT

I, _____, the parent or guardian of _____ recognize that during this event, medical treatment on an emergency basis may be necessary and further recognize that school personnel may be unable to contact me for my consent for such emergency medical care; I do hereby consent in advance to such emergency care, including hospital care, as may be deemed necessary under the then existing circumstances and to assume the expenses of such care.

_____ _____
Signature of Parent or Guardian Date

Father's (or Guardian's) Name _____ Mother's (or Guardian's) Name _____

Home Phone _____ Home Phone _____

Cell Phone _____ Cell Phone _____

Employer _____ Employer _____

Daytime Phone _____ Daytime Phone _____

Name of student's Medical Insurance_____ Name of student's Medical Insurance _____

Contract/Group Number _____ Contract/Group Number _____

My Child's Daily Medication: _____

Allergic To: _____ Date of last Tetanus: _____

Please list any medical or chronic conditions of which attending school officials should be aware: _____

_____

If neither parent (or guardian) can be reached, emergency care will be given by:

Friend _____ Relationship_____ Phone _____

Friend _____ Relationship_____ Phone _____

In the case that my child has an accident or serious illness, I request that the school contact me. If I cannot be reached, I authorize the school to call the physician/dentist indicated below and to follow his/her instructions. If my physician/dentist cannot be reached, the school may take whatever measures seem necessary.

Physician _____ Phone _____

Dentist _____ Phone _____

Also complete reverse side of this form. Thank you.

Revised 4-29-26